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In the Supreme Court of the United States

January Term, 1979
No. 78-1318

HELEN B. O'BANNON, SECRETARY OF PUBLIC WELFARE,
Petitioner

vs.

TOWN COURT NURSING CENTER, et al.,
Respondents

On Writ of Certiorari to the United States Court of Appeals for the Third Circuit.

BRIEF FOR PETITIONER

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II. OPINIONS BELOW

The majority and dissenting opinions of the Court of Appeals are reported at 586 F.2d 280 and are set out in the appendix at 144a, 181a.

III. JURISDICTION

The judgment of the Court of Appeals was entered on September 29, 1978. The Petition for Certiorari was filed on February 26, 1979 and granted on April 16, 1979. The jurisdiction of this Court is invoked pursuant to 28 U.S.C. §1254.

IV. QUESTION PRESENTED

Whether the Medicaid program entitles recipients residing in a nursing home to notice and an opportunity for a hearing in connection with a state's termination of that nursing home from its Medicaid program?

V. STATUTES INVOLVED

Each of the following is set out in an appendix to this brief at pp. 22-27:

42 U.S.C. §1396a (a) (28) (Supp. 1970)
42 U.S.C. §1395x (j) (1970)
42 U.S.C. §1396a (a) (23) (Supp. 1970)
42 C.F.R. §405.1121 (k) (4).

VI. STATEMENT OF THE CASE

A. Statutory Scheme

Skilled nursing home care is one of a host of health care services which may be publicly funded under both Title XVIII (Medicare)[1] and Title XIX (Medicaid)[2] of the Social Security Act. The conditions which a nursing home must satisfy in order to participate in either program are set forth in Title XVIII, 42 U.S.C. §1395x (j) (1970). Title XIX simply requires that before a facility may qualify as a Medicaid provider it must satisfy all of the requirements under Title XVIII, 42 U.S.C. §1396a (a) (28) (Supp. 1970).

These conditions of participation are found both in the Act, 42 U.S.C. §1395x (j) (1970), and in federal regulations, 42 C.F.R. §405.1101 *et seq.*, 42 C.F.R. §442.200. Generally, Congress has established the broad requirements for such nursing homes. For example, the Act establishes minimum requirements for professional staffing and fiscal accountability. *See* 42 U.S.C. §1395x (j) (6), (10) (1970). The more specific conditions, on the other hand, have been provided by regulations of the Department of Health, Education and Welfare (H.E.W.). *See* 42 C.F.R. §405.1101 *et seq.*, 42 C.F.R. 442.200. Thus, H.E.W. has promulgated a complete set of criteria relating to such areas as the minimum educational requirements for professional staff, physician services, di-

[1] 42 U.S.C. §1395 *et seq.* (1970).
[2] 42 U.S.C. §1396 *et seq.* (1970).

etetic services, and specialized rehabilitative services. 42 C.F.R. §§405.1101, 405.1123, 405.1125, 405.1126.

The primary responsibility for surveying nursing homes to determine their compliance with these conditions has been delegated to the states. 42 U.S.C. §1395aa(a) (Supp. 1970). In Pennsylvania, these surveys are performed by the Pennsylvania Department of Health. A team of inspectors is sent to each facility to determine whether it meets all of the conditions of participation[3]. The management of the home is notified of any deficiencies and, if its plan for correcting them is acceptable, it is recommended that the facility be certified as a qualified provider.[4] If the Secretary of H.E.W. or the State Medical Administrator accepts this recommendation, a provider agreement is entered into with the facility.[5]

Annually, each facility is resurveyed to assess its continued eligibility to participate. If the state determines that a particular home is irredeemably out of compliance with these conditions, it must then recommend that the facility's certification as a Medicare provider either not

[3] The actual procedure involves inspection of the plant as well as interviews with staff and residents to determine compliance with all health and safety requirements. See note 20 *infra*.

[4] If the particular nursing home is only seeking Medicaid certification, then this recommendation goes to the state agency responsible for the administration of that state's medical assistance program. If, as in this case, the facility is also seeking Medicare certification, then the survey team's recommendation is made directly to H.E.W.

[5] These agreements may not exceed 12 months in duration. 42 C.F.R. §405.1902(b), 42 C.F.R. 442.15(a). An extension of a Medicaid provider agreement is permitted for a maximum of two months under certain conditions. 42 C.F.R. §442.16.

be renewed or be terminated. If the Secretary of H.E.W. agrees, the facility is notified by the state Medicaid and Federal Medicare administrators of its termination under both programs. 42 C.F.R. §405.614. The provider is then entitled to a series of post-termination review proceedings. 42 C.F.R. §405.1501 *et seq.*, 44 Fed. Reg. 9753 (1979) (to be codified in 42 C.F.R. 431.151 *et seq.*). On the other hand, the residents of that nursing home who are receiving services under Medicare or Medicaid are not themselves provided any hearing, either pre- or post-termination.[6]

B. History of These Proceedings

Originally certified in 1967 as both a Medicare and Medicaid provider, the Town Court Nursing Center (hereafter "Town Court") has had a history of non-compliance with the conditions of participating in these programs (31a-35a, 54a-61a, 271a-278a, 280a, 296a). In 1974, the Pennsylvania survey team concluded that the facility was so substantially out of compliance that it was no longer qualified to participate in either program. Accordingly, the team recommended to H.E.W. that Town Court be terminated as a Medicare provider (36a). After a series of negotiations, extensions, and short term agreements, Town Court was terminated as a provider under Medicare and Medicaid effective October 31, 1974 (33a).

Late in 1974, Town Court applied for readmission to these programs. Surveys of the facility were conducted by the Pennsylvania Department of Health, and in April

[6] However, in Pennsylvania the residents may participate in any review proceedings initiated by the facility. 1 Pa Code §35.28.

of 1976, Pennsylvania recommended that H.E.W. certify the facility as a qualified Medicare provider (33a). Town Court was thereafter recertified as a skilled nursing home under both Medicare and Medicaid. Pennsylvania and Town Court accordingly entered into a provider agreement for provision of nursing home services under Medicaid (33a).

In July of 1976, H.E.W. itself surveyed Town Court (33a). The survey team found serious deficiencies and requested a special survey of the facility by the Pennsylvania officials. Pennsylvania then surveyed the facility in November of 1976, and again in March of 1977. After consultations with Town Court management regarding the deficiencies which had been found and consideration of a plan of correction by Town Court, the Pennsylvania Department of Health recommended that Town Court's provider agreement, which was due to expire on April 30, 1977, not be renewed (34a, 273a, 423a).[7] On the basis of this, H.E.W. concluded that Town Court was no longer qualified to provide nursing home services. Accordingly, H.E.W. notified the facility that it would be terminated under the Medicare program on June 18, 1977. As a result, Petitioner informed the facility that it was not qualified to participate in the Pennsylvania Medicaid program and would be terminated on the same date.[8] (9a, 291a-299a).

[7] The record shows that the deficiencies which were found by both the federal and state survey teams included serious deficiencies in the areas of medical direction (42 C.F.R. §405.1122); physician services (42 C.F.R. §405.1123), and nursing services (42 C.F.R. §405.1124) (33a-34a, 423a-494½a).

[8] Town Court was given these notices on May 17, 1977. Pursuant to federal regulations, it was entitled to, and received, thirty days prior notice of termination. 42 C.F.R. 405.615(a).

Town Court then commenced administrative review proceedings within H.E.W. However, before a decision had been reached on the requested reconsideration, this suit was initiated. On July 20, 1977, Town Court, on its own behalf together with six named residents,[9] sought a restraining order prohibiting the facility's termination under the Medicare and Medicaid programs (15a). In their complaint, plaintiffs charged that the Due Process Clause required that they be given notice and a hearing before the facility was terminated (12a-13a). The defendants were the Pennsylvania Secretary of Public Welfare and the Secretary of H.E.W.

On July 21, 1977, the District Court preliminarily enjoined the defendants from terminating Town Court (22a-23a). The injunction was then extended to allow the completion of H.E.W.'s administrative review process which Town Court had already initiated (288a-289a). However, when the decision to terminate the facility was affirmed by H.E.W., the plaintiffs then applied to the District Court for a further extension of the original injunction (28a). On September 15, 1977, that request was denied and the injunction was dissolved, except that the defendants were ordered to reimburse Town Court for all Medicaid "services actually provided to patients" (117a).

H.E.W. appealed that portion of the District Court's order requiring payments to Town Court beyond June 18, 1977, and Town Court, along with the six residents, appealed from the court's dissolution of the injunction. In

[9] Although brought as a class action on behalf of "patients eligible for Pennsylvania medical assistance benefits at Town Court Nursing Center, Inc." (7a-8a, 11a), the District Court never certified a class (147a).

addition, Town Court and the residents sought an injunction pending appeal prohibiting the termination of Town Court (124a). The Court of Appeals issued that injunction (142a). Accordingly, Town Court continues to receive Medicaid funding from both the federal and state government.[10]

On the merits, the Court of Appeals issued two separate opinions. In the first, Chief Judge Seitz, for the Court, ruled that Town Court on its own behalf had no right to a pre-termination evidentiary hearing.[11] In its second opinion, Judge Aldisert, for the Court, concluded that the residents of Town Court *were* entitled to a hearing before the facility was terminated (149a), *Town Court v. Beal*, 586 F.2d 280, 282-3 (3d Cir. 1978). In addition, the Court affirmed the District Court's order requiring continued funding of Town Court by Pennsylvania and H.E.W.[12]

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[10] As part of its separate obligations under state law, Pennsylvania has continued to monitor the facility and has issued it licenses under state law. Pa. Stat. Ann. Tit. 62, §1001 *et seq.* (Purdon). 28 Pa. Code §201.1 *et seq.*

[11] With respect to this claim, the Court of Appeals correctly concluded that:

> [I]n light of the extensive procedural safeguards already provided to facilities such as Town Court we believe it clear that any interest Town Court might have in continued certification under the Medicare program is adequately protected by existing procedures.

Town Court v. Beal, 586 F.2d 266, 278 (3d Cir. 1978).

[12] This aspect of the Court's order appears to be somewhat inconsistent with its order in the first decision which provides that "[t]he order of the district court continuing in effect part of the preliminary injunction will be reversed as to Town Court". *Compare* Town Court, 586 F.2d at 280 with (150a) Town Court, 586 F.2d at 283, but see Town Court, 586 F.2d at 268.

The Court of Appeals ruling with respect to the Town Court residents is presently under review. The six named residents of Town Court had contended they were independently entitled to a hearing before it was determined that Town Court was not qualified to participate in the Medicaid program. They contended that they would suffer a *de facto* loss of Medicaid benefits with the termination of Town Court as a provider of Medicaid services. The Court of Appeals agreed, concluding that they were entitled to notice and a hearing before the facility was terminated under the program (149a), *Town Court v. Beal*, 586 F.2d. at 282-3. Although the Court of Appeals never prescribed the precise ingredients which would be requiring in such a hearing—leaving that to the District Court on remand—petitioner believes this threshold ruling to be wrong and seeks reversal of it here.[13]

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[13] The Secretary of H.E.W., on the other hand chose not to seek certiorari. Nevertheless, the Solicitor General has informed the Clerk that the Secretary will file a brief in support of Petitioner.

VII. SUMMARY OF ARGUMENT

The residents of Town Court have claimed a "property interest" under Pennsylvania's Medical Assistance Program which, they contend, has been adversely affected by Petitioners' determination that Town Court was not qualified to participate in the program as a provider of nursing home care. Thus, they asserted their entitlement to a hearing before the facility could be terminated as a Medicaid provider.

The lower court agreed, concluding that the disqualification of Town Court was "tantamount to an order to transfer . . ." and therefore, a reduction in their Medicaid benefits. *Town Court v. Beal*, 586 F.2d 280, 282-3 (3d Cir. 1979). Accordingly, the Court of Appeals ordered that before Town Court could be terminated under the program, hearings were required for all of its Medicaid residents. The Court based this ruling on three separate provisions in the Medical Assistance Program: the recipients' statutory right to choose freely among providers; the regulatory limitations on the transfer of nursing home residents; and the requirement of prior notice and hearing before recipients' benefits can be reduced or terminated.

The Court of Appeals approach is wrong because the provisions of the Medicaid program on which it relied are simply inapplicable to the governmental determination of a provider's qualifications to participate in the program. For example, the recipients' statutory right to freely choose among Medicaid providers has not been adversely

affected because that right is explicitly limited to choosing among *qualified* providers. Similarly, the regulatory restrictions on the transfer of nursing home patients do not restrict the Petitioners' statutory responsibility to insure that only qualified nursing homes participate in the program. Thus, the Town Court residents have not had their benefits reduced, for they remain eligible to receive nursing home care from any qualified provider.

Similarly Judge Adams, in his concurring opinion has overlooked certain important considerations which preclude such a loose reading of the statutes and regulations which are involved.

It is, therefore, not surprising that other Courts of Appeals have differed with the lower Court in cases remarkably similar to this one. *Moore v. Johnson*, 582 F. 2d 1228 (9th Cir. 1978); *Caton Ridge Nursing Home v. Califano*, 447 F. Supp. 1222 (D. Md. 1978), *aff'd* Medicare and Medicaid Guide ¶29,631 (Per Curiam). The decision of the lower court represents an unwarranted extension of due process which will invite administrative paralysis in this important program. Accordingly, the decision should be reversed.

VIII. ARGUMENT

The Medicaid Program Does Not Entitle Recipients Residing in a Nursing Home to Notice and an Opportunity for a Hearing in Connection With a State's Termination of That Nursing Home From the Medicaid Program

This case raises the discrete question of whether Medicaid recipients of skilled nursing home services have a property interest under that program which is adversely affected when their particular home is terminated as a qualified provider of Medicaid services. The existence of such an interest in the residents is the necessary predicate to the imposition of the procedural protections of the Due Process Clause. Although traditional notions of real or personal property do not determine what is, and is not, a protectable property interest, more than a mere "unilateral expectancy" of a particular benefit is required. Similarly, while the distinction between "right" and "privilege" in this area has long since been discarded, more than an "abstract need or desire" must be demonstrated before the Due Process Clause will apply. *Board of Regents of State Colleges v. Roth,* 408 U.S. 564, 577 (1972). Thus a "subjective expectancy" of a governmental benefit standing alone will not support a claim to due process. *Perry v. Sinderman,* 408 U.S. 593, 603 (1972).

The Constitution itself is not the source for any particular property rights. *Board of Regents of State Colleges v. Roth, supra.* Rather, "the underlying substantive

interest is created by 'an independent source such as state law.' " *Memphis Light, Gas and Water Division v. Craft,* 436 U.S. 1 (1978). Accordingly, in this case the Town Court residents must ground their claim to a property interest in the federal and state laws which establish Pennsylvania's Medical Assistance program.

At the outset, it is clear that a recipient of nursing home care under Medicaid is only entitled to receive that care from a provider that is eligible to participate in the program. 42 U.S.C. §1395f(a) (1970); 42 U.S.C. §1396a(a) (28) (Supp. 1970). Indeed, the Court of Appeals has acknowledged this important point. *Klein v. Califano,* 586 F.2d at 258. Moreover, there is certainly nothing in either federal or state law which explicitly grants the residents of a particular nursing home a hearing before that home may be terminated as a Medicaid provider. Nevertheless, the Respondents argue that the Medicaid program, as presently drawn, provides them with an interest in the continued eligibility of a nursing home which both the state and federal governments have found to be unqualified to provide services under the program. The Court of Appeals agreed,[14] concluding that several statutory and regulatory provisions, taken together implicitly created such a property right in the residents.

The lower Court relied upon three provisions of the Medicaid program for its decision. First, the Court noted that Congress has guaranteed eligible recipients the right to freely choose among providers participating in the

[14] In this case, the Court of Appeals merely adopted the reasoning which it articulated in Klein v. Califano, 586 F.2d 250 (3d Cir. 1978) (149a).

program. 42 U.S.C. §1396a(a) (23) (Supp. 1970)[15] Next, the Court focused upon the Medicaid regulations as well as decisions of this Court which require that a Medicaid recipient be afforded a hearing before his benefits are diminished. 44 Fed. Reg. 17932 (1979) (to be codified in 42 C.F.R. §431.200 *et seq.*), *Goldberg v. Kelly*, 397 U.S. 254 (1970).[16] Finally, the Court relied on the federal regulation which prohibits the transfer of nursing home residents by the nursing home operator except under limited circumstances.[17] Taken together, these provisions, in the lower court's view, established that the patients' benefits could be "discontinued only on the occurrence of specified reasons or for cause . . ." *Klein v. Califano*, 586 F.2d at 258. The Court then concluded that the determination that a nursing home was unqualified to participate in the Medicaid program was "tantamount to an order to transfer the patient" which in turn constituted a diminution in his benefits. *Id.*

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[15] This section provides:

> A State plan for medical assistance must—except in the case of Puerto Rico, the Virgin Islands, and Guam, provide that any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy, or person, qualified to perform the service or services required (including an organization which provides such services, or arranges for their availability, on a prepayment basis), who undertakes to provide him such services.

[16] In that case, this Court held that a welfare recipient's benefits could not be reduced or terminated without prior notice and hearing. Goldberg v. Kelly, 397 U.S. 254 (1970).

[17] This regulation requires that the nursing home operator not transfer a patient except for:

> . . . medical reasons, or for his welfare or that of other patients, or for non-payment of his stay (except as prohibited by Titles XVIII or XIX of the Social Security Act), and is given reasonable advance notice to ensure orderly transfer or discharge, and such actions are documented in his medical record.

42 C.F.R. §405.1121(k)(4).

In the first instance, this approach fails to recognize that the residents' statutory right to choose freely among providers has not been adversely affected. The statute itself limits their choice to *qualified* providers and that choice remains to them. 42 U.S.C. §1396a(a)(23) (Supp. 1970). Undoubtedly the termination of a provider such as Town Court will indirectly affect its residents but that alone is not sufficient to uphold the reasoning of the lower Court. Indeed the majority's analysis would logically apply in the provision of most governmental benefits. For example, it would seem that before a physician could be excluded as a Medicaid provider his patients would be entitled to a hearing on the matter. Carrying the Court of Appeals' reasoning even further, it would follow that a Medicaid recipient's right to choose providers would also be infringed when the government refuses initially to admit a provider into the program. This clearly was not intended by Congress. "Decisions of the Executive Branch, however serious their impact, do not automatically invoke due process protection; there simply is no constitutional guarantee that all executive decision making must comply with standards that assure error-free determinations." *Greenholtz v. Inmates of Nebraska Penal and Correctional Complex*, 47 U.S.L.W. 4581, 4583 (May 29, 1979).

The Court of Appeals also misperceived the regulations limiting the circumstances under which a Medicaid recipient may be transferred from one facility to

another. 42 C.F.R. §405.1121 (k) (4). This provision does not restrict the Petitioner's authority and duty under the Act to determine whether or not a particular nursing home is qualified to participate in the program. Rather it prohibits operators of participating homes from transferring Medicaid clients without cause. The decision of the Petitioner to terminate Town Court has, therefore, not affected these statutory rights of respondents *vis-a-vis* operators of eligible nursing home providers.

Finally, the fair hearing provisions contained in 44 Fed. Reg. 17932, *supra.* provide no substantive benefits to Medicaid recipients, but merely establish a procedure to adjudicate government attempts to reduce their benefits. Here, however, the residents' entitlements under Title XIX have not been diminished in the least. Their eligibility for medical assistance benefits has simply not been affected by the termination of Town Court. Rather, they remain eligible to receive the same level of nursing home care. However, as always, their eligibility for this care extends only to qualified nursing homes.

Without disputing any of this, Judge Adams[18] nevertheless concluded that reliance on the actual language of each of these statutory and regulatory provisions "tend-[ed] to trivialize the [court's] approach in inferring a basis for the right to due process" (159a), *Town Court v. Beal,* 586 F.2d at 287. To these members of the court, the provisions relied upon implicitly "paint[ed] three distinct points in the landscape of a 'legitimate claim of entitlement' ". *Id.* This admittedly loose construction of the statute and regulations was warranted, in their view,

[18] Judge Adams' concurring opinion is particularly important because four of the six members of the majority joined in it.

because of the increasing role programs such as Medicaid play in society today, 166a, *Town Court v. Beal,* 586 F. 2d at 289, as well as the indirect effect the termination of Town Court would have on its residents, 165a, *Town Court v. Beal,* 586 F.2d at 289. Thus, these "new forms of property", according to Judge Adams, were to be accorded the protection of the Due Process Clause. 166a, *Town Court v. Beal,* 586 F.2d at 289.

This analysis however overlooks certain fundamental considerations. First, courts may not lightly disregard the statutory language used by Congress to create programs such as Medicaid. *Southeastern Community College v. Davis,* 47 U.S.L.W. 4689, 4691 (June 11, 1979), *Beal v. Doe,* 432 U.S. 438 (1977). The manner of distributing public benefits is the province of Congress and the statutory language which is carefully used to accomplish this must be honored by the courts. In this case the Court of Appeals conceded that Congress has not explicitly given Medicaid recipients a role in the approval or disapproval of Medicaid providers in the program, and it was not free to ignore this and infer statutory entitlements that Congress has not provided.

Next, although the weight of the patient's concern regarding the termination of a nursing home provider is relevant to the nature of the process which may ultimately be due, it is not determinative of the threshold question of whether or not the patients have a protectable interest in that decision. *Mathews v. Eldridge,* 424 U.S. 319 (1976); *Board of Regents of State Colleges v. Roth,* 408 U.S. 564 (1974). If this were not so, there simply would be no limit to the application of the Due Process Clause. As the lower court recognized, programs like Medicaid

are pervasive in today's society. 166a, *Town Court v. Beal,* 586 F.2d at 289. That being so, the spectre of due process being triggered at every turn in the administration of these programs is a compelling reason for rejecting the Court of Appeals analysis. For example it would be impossible to effectively insure quality health care under Medicaid if before a physician could be terminated each of his Medicaid patients were required to be given prior notice and hearing on the matter. Similarly, if everyone indirectly affected by the termination or letting of a particular government contract had to be given prior notice and hearing on the question, government contracting would rapidly come to a complete standstill.

Like so many government programs today, Medicaid involves contractual arrangements between the government and the actual providers of the benefits, as well as a direct relationship between the individual recipient and the government. Although both the recipients and the providers must satisfy certain statutorily imposed standards to participate in the program, these eligibility determinations are entirely separate and distinct.[19] Just as the statute and regulations accord the provider no interest in the determination of a recipient's eligibility, neither does it create an interest in the recipient in determining the provider's qualifications. While it is undoubtedly true that the decision to terminate a facility such as Town Court is a matter of great importance to its residents, that alone is simply not sufficient to trigger the requirements of the Due Process Clause. *Greenholtz v. Inmates of the Nebraska Penal and Correctional Complex, supra; Meachum v. Fano,* 427 U.S. 215, 224 (1975); *Board of Regents of State Colleges v. Roth, supra.*

[19] Indeed, entirely different rules apply when a provider rather than a recipient is determined to be ineligible to participate in the program. Thus, while a recipient is entitled to prior notice and a hearing before his Medicaid benefits are terminated, a provider is only entitled to post termination review. *Compare* 44 Fed. Reg. 17932 (1979) (to be codified in 42 C.F.R. §431.200) (recipient's rights to hearing before termination of eligibility for Medicaid benefits) with 44 Fed. Reg. 9753 (1979) (to be codified in 42 C.F.R. §431.151 *et seq.*) (Hearing for the facility is not necessary until 120 days after termination).

Finally, the concurring opinion assumes that the patients would be competent to offer relevant information on the issue of whether or not the nursing home is in compliance with the requirements of the program. However, the conditions of participation for nursing homes in the Medicaid program are, of necessity, technical matters requiring expert evaluation. In these areas, the patients' opinions certainly will not significantly reduce the risk that the government will make a mistaken assessment of the nursing home's compliance. For example, it is unlikely that the residents of Town Court could offer any meaningful information on the professional qualifications of the medical staff or the fiscal responsibility of that facility. *Caton Ridge Nursing Home, Inc. v. Califano,* 447 F. Supp. 1222 (D. M.D. 1978, *aff'd* No. 78-1290 (4th Cir. filed Feb. 26, 1979). Indeed to the extent these matters may be in dispute, it is entirely reasonable to assume that the operator of the nursing home will bring all the relevant information to bear on the question in order to protect his investment. 186a, *Town Court v. Beal,* 586 F.2d at 297 (Seitz, C.J. dissenting).

Perhaps recognizing these difficulties, other Courts of Appeals in similar cases have reached a result contrary to that reached by the Court of Appeals in this case.

In *Moore v. Johnson*, 582 F.2d 1228 (9th Cir. 1978), the administrator of the Veterans' Administration decided that certain of its domiciliary care facilities were structurally deficient and could therefore no longer be used in the program. Accordingly, the residents were informed that they would be relocated to a qualified facility of their choice. The residents filed suit claiming a right to a pre-relocation hearing under the Due Process Clause of the Fifth Amendment.

The Court of Appeals for the Ninth Circuit, affirming the District Court, unanimously concluded that the plaintiffs' "belief that the Administrator *must* furnish domiciliary care and vocational training benefits at *specific facilities in Los Angeles* . . . are mere 'unilateral expectations.'" 582 F.2d at 1234 (emphasis in original). In *Moore*, the court noted that a contrary ruling would result in severe inflexibility in the administration of the program. Finally, the Court recognized that although the impact of the Administrator's decision was a matter of great urgency to the patients, this alone was insufficient to establish rights under the Due Process Clause. Addressing these concerns, the court pointed out that:

> Similar burdens always attend an extensive distribution of benefits by government; inescapably few get exactly what they want, while most, it is usually assumed, get more than they would have otherwise. All would get less if invariably the complaints of the many required elaborate hearings with all the trappings that only lawyers and judges can fully appreciate.

Moore v. Johnson, 582 F.2d at 1234.

The Court of Appeals for the Fourth Circuit has also reached this result in affirming a district court ruling in a factual setting akin to this case. In *Caton Ridge Nursing Home, Inc. v. Califano*, 447 F. Supp. 1222 (D. Md. 1978), a nursing home and a patient sought to enjoin both the State of Maryland and H.E.W. from terminating the home as a Medicaid provider, claiming rights similar to those asserted in this case. Recognizing that the "proper implementation of the Due Process Clause calls for a practical, pragmatic analysis", the district court dismissed the resident's complaint finding that the patients had no property interest at stake. *Id.* at 1226. The *Caton Ridge* Court was also concerned with the effect of a contrary finding on the administration of the program. The Fourth Circuit in an unpublished *per curiam* opinion affirmed the District Court's conclusion that the residents of Caton Ridge simply had no interest requiring that they be given a hearing before the facility could be terminated as a provider of services under the Medicaid program.[20]

The approach taken in *Moore* and *Caton Ridge* is correct. These decisions recognize that the termination of a provider such as Town Court simply ends a contractual relationship between the facility and the government, but does not deprive its residents of any of their statutory entitlements. Pennsylvania is nevertheless aware that the patients are affected by such a decision and does

[20] This opinion, although officially unpublished, can be found at CCH Medicare and Medicaid Guide—¶29,631 and is reproduced as Exhibit "A" to Respondent's Brief in Opposition to Petition for Writ of Certiorari at 13. In that opinion, the Court distinguished Klein because the nursing home deficiencies in Klein, as in Town Court, involved services to patients rather than structural defects in the facility itself. The lower court in Klein noted

not intend to minimize its seriousness here.[21] However, this does not alter the inescapable conclusion that the residents of Town Court stand in a significantly different position than did the welfare recipient whose benefits were summarily terminated in *Goldberg v. Kelly*, 397 U.S. 254 (1970), the teacher whose contract was terminated in *Perry v. Sinderman, supra*, or the family whose utilities were summarily shut off in *Memphis Light, Gas and Water Division v. Craft, supra*. Unlike these cases, Town Court's residents, although affected by the decision to terminate the facility, have never had their Medicaid entitlements jeopardized or even brought into question.

This distinction is critical. Governmental decisions in the administration of the countless programs which currently exist for the public's benefit indirectly affect thousands, if not millions, on a daily basis. If these pro-

that when deficient services were involved, the patients could contribute relevant information on the point, whereas structural problems would apparently be beyond their competence. Klein v. Califano, 586 F.2d at 260 n. 17.

Although this may or may not be true, it is irrelevant to this inquiry. Whether or not a property interest exists in a given situation does not turn on the ability of a particular individual to offer relevant information on the question, but rather upon the nature of the interest which is affected. Meachum v. Fano, 427 U.S. 222, 224 (1975). It is nevertheless important to note that Pennsylvania's survey procedure does require the survey team to seek the views of the patients during compliance surveys. State Survey Agency Long Term Care Manual, U.S. Department of Health, Education and Welfare (Washington, D.C. 1975), Appendix A at 23.

[21] Recognizing the difficulties in the transfer of nursing home patients, Pennsylvania has developed a program to accomplish these relocations without needless inconvenience and suffering.

grams are not to become paralyzed in a procedural maze, their administrators must be given sufficient latitude to make the necessary administrative decisions promptly and efficiently. While Petitioner certainly does not urge that administrators be given unfettered discretion, the Court of Appeals decision in this case invites administrative paralysis. In the area of nursing home care for the disabled, the Petitioner must be able to quickly and effectively terminate unqualified nursing home providers under its Medicaid program. Such a decision of necessity affects many Medicaid residents; yet it would be entirely unreasonable to require a hearing in each case.

In fact this program has been used as a national model by H.E.W. See Technical Assistance Memorandum: Development of Nursing Home Patient's Relocation Plans, United States Department of Health, Education and Welfare (Feb. 19, 1975).

IX. CONCLUSION

Based upon the foregoing arguments and authorities, Petitioner urges that the ruling of the Court of Appeals for the Third Circuit must be reversed.

Respectfully submitted,

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APPENDIX

42 U.S.C. §1396a (a) (28):

A State plan for Medical Assistance must provide that any skilled nursing facility receiving payments under such plan must satisfy all of the requirements contained in section 1395x (j) of this title, except that the exclusion contained, therein with respect to institutions which are primarily for the care and treatment of mental diseases and tuberculosis shall not apply for purposes of this subchapter;

42 U.S.C. §1395x (j):

Skilled nursing facility

The term "skilled nursing facility" means (except for purposes of subsection (a) (2) of this section) an institution (or a district part of an institution) which has in effect a transfer agreement (meeting the requirements of subsection (*l*) of this section) with one or more hospitals having agreements in effect under section 1395cc of this title and which—

(1) is primarily engaged in providing to inpatients (A) skilled nursing care and related services for patients who require medical or nursing care, or (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons;

(2) has policies which are developed with the advice of (and with provision of review of such policies from time to time by) a group of professional

personnel, including one or more physicians and one or more registered professional nurses, to govern the skilled nursing care and related medical or other services it provides;

(3) has a physician, a registered professional nurse, or a medical staff responsible for the execution of such policies;

(4) (A) has a requirement that the health care of every patient must be under the supervision of a physician, and (B) provides for having a physician available to furnish necessary medical care in case of emergency;

(5) maintains clinical records on all patients;

(6) provides 24-hour nursing service which is sufficient to meet nursing needs in accordance with the policies developed as provided in paragraph (2), and has at least one registered professional nurse employed full time;

(7) provides appropriate methods and procedures for the dispensing and administering of drugs and biologicals;

(8) has in effect a utilization review plan which meets the requirements of subsection (k) of this section;

(9) in the case of an institution in any State in which State or applicable local law provides for the licensing of institutions of this nature, (A) is licensed pursuant to such law, or (B) is approved, by the agency of such State or locality responsible for licensing institutions of this nature, as meeting the standards established for such licensing;

(10) has in effect an overall plan and budget that meets the requirements of subsection (z) of this section;

(11) complies with the requirements of section 1320a-3 of this title;

(12) cooperates in an effective program which provides for a regular program of independent medical evaluation and audit of the patients in the facility to the extent required by the programs in which the facility participates (including medical evaluation of each patient's need for skilled nursing facility care);

(13) meets such provisions of the Life Safety Code of the National Fire Protection Association (23d edition, 1973) as are applicable to nursing homes; except that the Secretary may waive, for such periods as he deems appropriate, specific provisions of such Code which if rigidly applied would result in unreasonable hardship upon a nursing home, but only if such waiver will not adversely affect the health and safety of the patients; except that the provisions of such Code shall not apply in any State if the Secretary finds that in such State there is in effect a fire and safety code, imposed by State law, which adequately protects patients in nursing facilities;

(14) establishes and maintains a system that (A) assures a full and complete accounting of its patients' personal funds, and (B) includes the use of such separate account for such funds as will preclude any commingling of such funds with facility funds or with the funds of any person other than another such patient; and

(15) meets such other conditions relating to the health and safety of individuals who are furnished services in such institution or relating to the physical facilities thereof as the Secretary may find necessary (subject to the second sentence of section 1395z of this title), except that the Secretary shall not require as a condition of participation that medical social services be furnished in any such institution. Notwithstanding any other provision of law, all information concerning skilled nursing facilities required by this subsection to be filed with the Secretary shall be made available to Federal or State employees for purposes consistent with the effective administration of programs established under subchapters XVIII and XIX of this chapter;

except that such term shall not (other than for purposes of subsection (a) (2) of this section) include any institution which is primarily for the care and treatment of mental diseases or tuberculosis. For purposes of subsection (a) (2) of this section, such term includes any institution which meets the requirements of paragraph (1) of this subsection. The term "skilled nursing facility" also includes an institution described in paragraph (1) of subsection (y) of this section, to the extent and subject to the limitations provided in such subsection. To the extent that paragraph (6) of this subsection may be deemed to require that any skilled nursing facility engage the services of a registered professional nurse for more than 40 hours a week, the Secretary is authorized to waive such requirement if he finds that—

(A) such facility is located in a rural area and the supply of skilled nursing facility services in

such area is not sufficient to meet the needs of individuals residing therein,

(B) such facility has one full-time registered professional nurse who is regularly on duty at such facility 40 hours a week, and

(C) such facility (i) has only patients whose physicians have indicated (through physicians' orders or admission notes) that each such patient does not require the services of a registered nurse or a physician for a 48-hour period, or (ii) has made arrangements for a registered professional nurse or a physician to spend such time at such facility as may be indicated as necessary by the physician to provide necessary skilled nursing services on days when the regular full-time registered professional nurse is not on duty.

42 U.S.C. §1396a (a) (23) (Supp. 1970):

A State plan for Medical Assistance must except in the case of Puerto Rico, the Virgin Islands, and Guam, provide that any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy, or person, qualified to perform the service or services required (including an organization which provides such services, or arranges for their availability, on a prepayment basis), who undertakes to provide him such services.

42 C.F.R. §405.1121 (K) (4):

Standard: Patients' rights. The governing body of the facility establishes written policies regarding the rights and responsibilities of patients and, through the administrator, is responsible for development of, and adherence

to procedures implementing such policies. These policies and procedures are made available to patients, to any guardians, next of kin, sponsoring agency(ies), or representative payees selected pursuant to section 205(j) of the Social Security Act, and Subpart Q of 20 CFR Part 404, and to the public. The staff of the facility is trained and involved in the implementation of these policies and procedures. These patients' rights policies and procedures ensure that, at least, each patient admitted to the facility:

Is transferred or discharged only for medical reasons, or for his welfare or that of other patients, or for nonpayment of his stay (except as prohibited by title XVIII or XIX of the Social Security Act), and is given reasonable advance notice to ensure orderly transfer or discharge, and such actions are documented in his medical record.